(v) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with § 155.410 or § 155.420.

(c) *Termination of coverage tracking and approval.* The Exchange must—

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of coverage;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with § 155.400(b).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) *Effective dates for termination of coverage.* (1) For purposes of this section—

(i) Reasonable notice is defined as at least fourteen days before the requested effective date of termination; and

(ii) Changes in eligibility for advance payments of the premium tax credit and cost sharing reductions, including terminations, must adhere to the effective dates specified in § 155.330(f).

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is—

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(iii) On a date on or after the date on which the termination is requested by the enrollee, subject to the determination of the enrollee's QHP issuer, if the enrollee's QHP issuer agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of QHP coverage is the day before the individual is determined eligible for Medicaid, CHIP, or the BHP.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of QHP coverage is the last day of eligibility, as described in § 155.330(f), unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of coverage will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of coverage should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

(7) In the case of a termination due to death, the last day of coverage is the date of death.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 78 FR 42322, July 15, 2013]

Subpart F—Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

SOURCE: 78 FR 54136, Aug. 30, 2013, unless otherwise noted.

§ 155.500 Definitions.

In addition to those definitions in §§ 155.20 and 155.300, for purposes of this subpart and § 155.740 of subpart H, the following terms have the following meanings:

Appeal record means the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

Appeal request means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have

any eligibility determination or redetermination contained in a notice issued in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) or (f), reviewed by an appeals entity.

Appeals entity means a body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) and (f).

Appellant means the applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

De novo review means a review of an appeal without deference to prior decisions in the case.

Evidentiary hearing means a hearing conducted where evidence may be presented.

Vacate means to set aside a previous action.

§155.505 General eligibility appeals requirements.

(a) *General requirements.* Unless otherwise specified, the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a State Exchange appeals entity or by the HHS appeals entity.

(b) *Right to appeal.* An applicant or enrollee must have the right to appeal—

(1) An eligibility determination made in accordance with subpart D, including—

(i) An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with the standards specified in §155.305(a) through (h); and

(ii) A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with §§155.330 and 155.335;

(2) An eligibility determination for an exemption made in accordance §155.605;

(3) A failure by the Exchange to provide timely notice of an eligibility determination in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), or 155.610(i); and

(4) A denial of a request to vacate dismissal made by a State Exchange appeals entity in accordance with §155.530(d)(2), made pursuant to paragraph (c)(2)(i) or this section; and

(c) *Options for Exchange appeals.* Exchange eligibility appeals may be conducted by—

(1) A State Exchange appeals entity, or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart; or

(2) The HHS appeals entity—

(i) Upon exhaustion of the State Exchange appeals process;

(ii) If the Exchange has not established an appeals process in accordance with the requirements of this subpart; or

(iii) If the Exchange has delegated appeals of exemption determinations made by HHS pursuant to §155.625(b) to the HHS appeals entity, and the appeal is limited to a determination of eligibility for an exemption.

(d) *Eligible entities.* An appeals process established under this subpart must comply with §155.110(a).

(e) *Representatives.* An appellant may represent himself or herself, or be represented by an authorized representative under §155.227, or by legal counsel, a relative, a friend, or another spokesperson, during the appeal.

(f) *Accessibility requirements.* Appeals processes established under this subpart must comply with the accessibility requirements in §155.205(c).

(g) *Judicial review.* An appellant may seek judicial review to the extent it is available by law.

§155.510 Appeals coordination.

(a) *Agreements.* The appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Such agreements must include a clear delineation of the responsibilities of each entity to support the eligibility appeals process, and must—